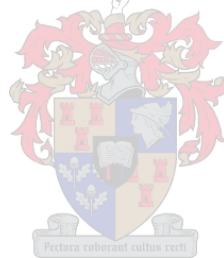


Employee perceptions towards outsourcing of HIV/AIDS services

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Declaration

By submitting this assignment electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the sole author thereof (save to the extent explicitly otherwise stated), that reproduction and publication thereof by Stellenbosch University will not infringe any third party rights and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

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Abstract

This study investigates the employee perceptions towards outsourcing of HIV/AIDS services in a retail working environment. Thirty participants were included using a self-administered questionnaire. The questionnaire assessed attitudinal disposition through questions aimed testing knowledge, preferences and environmental factors influencing perception towards alternative HTC service centres.

Results show employees have positive perceptions towards the utilisation of external HTC and welfare services compared to those offered on-site. On-site employer initiated HTC services through mobile testing facilities are perceived as failing to offer privacy, anonymity and security of continued employment as testing outside the employer's premises would provide. Outsourced services such as public hospitals or clinics are seen to offer better testing environment because of their natural health settings and non-association with the employer whose motives for providing testing services in the workplace are held in suspicion. Ninety four per cent of the employees expressed desire to have HTC services provided in the workplace. Potential utilisation level of such services dropped to 33% among these employees with 50% indicating a desire to use external health services providers. This disparity is explained by the negative environmental and social factors prevailing in the workplace which make access to HTC difficult.

Recommendations for improving employee attitudes towards on-site HTC services include implementing educational programs to reduce peer stigma, scepticism to employer motives for initiating health intervention programs and demonstrating fair employment practices which do not associate HIV status with different treatment in the workplace. There is also a need for companies to plan around facilitating employee use of public health facilities even when they have on-site services to promote a perception of holistic care towards employees.

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I give thanks to God for guiding me through the journey and holding the hope to go on. I also wish to acknowledge the invaluable contributions of the following individuals:

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I dedicate this work to my Mother

Abbreviations, Acronyms and Terms

HAART	Highly active antiretroviral therapy
HIV	Human Immunodeficiency Virus
AIDS	Acquired Immunodeficiency Syndrome
HTC	HIV Counselling and Testing
VCT	Voluntary Counselling and Testing
PLWHA	People Living with HIV/AIDS
ARVs	Antiretroviral tablets
UNAIDS	United Nations AIDS
PMCT	Prevention of Mother to Child Transmission
ART	Antiretroviral Therapy
WHO	World Health Organisation
TB	Tuberculosis
SABCOHA	South African Business Council for HIV/AIDS
UNICEF	United Nations Children's Educational Fund

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CHAPTER 1

INTRODUCTION

1.1 Introduction

Global HIV/AIDS statistics show Africa bears the largest burden of HIV/AIDS. A Stop Aids Now (2009:6) report asserts “the majority of those living with HIV and AIDS live in Sub-Saharan Africa, are employed and in their productive years with skills and experiences their families, workplaces and countries can ill afford to lose”. The HIV/AIDS phenomenon has not only negatively impacted on society but has extended its social costs to businesses. In response many private and public organisations globally and in South Africa have adopted HIV/AIDS policies to assist employees to deal with its challenges. Motivations for a company HIV/AIDS policy responses emanate from its felt impact on business performance, for good industrial relations climate in the workplace and the need to comply with national legislation regulating the provision of HIV/AIDS support services to employees. Thus the development and implementation of HIV/AIDS workplace policies that offer clear guidelines on how a business will manage it has become part of best practices in dealing with the infection.

Typical HIV/AIDS intervention programs that form part of workplace policy include guidelines on access to Voluntary Counselling and Testing (VCT) services, provision of antiretroviral therapy (ART), dealing with its stigma and discrimination among employees together with wellness benefit programs that extend to family members and the community. However, despite most businesses accepting the primary role to assist employees in dealing with HIV/AIDS challenges in the workplace many of these companies have opted to use external or outsourced related service providers to cater for employees’ needs rather than handle its management directly. This has meant employees are not being able to readily access HIV/AIDS services or are unwilling to visit the external service providers in the community to access their support requirements resulting on low uptake of these services such as VCT or receiving medical treatment. This observation is consistent with attitudes in some companies that do not have sound implemented HIV/AIDS policies and those that still do not accept or feel the burden of the infection in their operations (Versteeg,

2004). In South Africa the tendency to promote the use of external HIV/AIDS services is prevalent in many industries including the retail sector within which the subject of this research falls. Large companies in the mining industry in contrast have committed greater resources to HIV/AIDS where direct investment to provide onsite and sustainable interventions such as VCT and provision of ART to meet employee health welfare requirements. However, even where companies have introduced employee wellness programs to cater for their health needs the trend has been to contract external service providers to provide HIV/AIDS services such as VCT, either telephonically or in person, or the employer has actively motivated the employees to make use of public health services for this infection and general health concerns.

1.2 Research problem

There is limited knowledge about how perceptions towards outsourced or external HIV/AIDS services influence their acceptance among employees. The research problem probes on the desirability of outsourcing or externalising HIV/AIDS support services in the workplace by evaluating practical employee experiences when using this for testing and counselling, dealing with stigma and discrimination and issues of confidentiality and access to ART therapy. While George and Quinlan (2008:21) were able to find “many large companies report low uptake rates for VCT and ART, despite sophisticated programme designs and substantive financial investments” no substantial emphasis was placed on trying to understand how employee attitudes to outsourcing or putting services offsite did contribute towards the low incidence of using HIV/AIDS support services like VCT.

The problem is thus: How do the perceptions of employees towards outsourcing or externalising of HIV/AIDS services influence the uptake and use of these services?

1.3 Research aims

The aims of the study is to establish how employee perceptions towards outsourcing of HIV/AIDS services influence employee uptake and use of HIV/AIDS support services such as VCT.

1.4 Research objectives

The objectives of the study are:

- To identify HIV/AIDS support services employees require
- To establish employee experiences when accessing HIV/AIDS support services at external service providers
- To investigate on the frequency of use of outsourced HIV/AIDS programs
- To establish individual preferences on where to access HIV/AIDS services
- To provide guidelines for organisations to face reality

1.5 Significance of the study

The research will be beneficial for the purposes of improving the services offered under the company's HIV/AIDS policy as well as provide feedback on the quality of services as experienced by employees when they receive HIV/AIDS support services off-site. The study also provides insight into preferences on whether or not HIV/AIDS management in the company should be managed in-house or outsourced; both employees and employers will benefit. Employees will be able to determine HIV/AIDS services relevant to their needs while for the company the overall assessment of the quality of service and the desirability of outsourced HIV/AIDS management as gathered from employees can be used to restructure this management strategy for effective employee welfare management. In the relatively new field of HIV/AIDS management, there is need to add to the body of knowledge. This research is significant in building academic literature that can assist practical decision making when managing HIV/AIDS in the company.

1.6 Ethical considerations

This research is going to be conducted on a private business operation, permission from the company will be sought to conduct the study. Target participants informed consent and right to anonymity and confidentiality of data given will be secured. The researcher will emphasise this research is solely for academic purposes and will not be distributed to other external organisations. Both the participants and the company will be informed of their right to refuse or withdraw their active participation at any stage during this research exercise without consequences.

1.7 Research design and methods

A research design outlines the plan for collecting data from a group of individuals and how it is analysed and presented. According to Wyk [UWC: undated] “the research design articulates what data is required, what methods are going to be used to collect and analyse this data, and how all of this is going to answer your research question”. Given the subjective and behavioural focus of the research question and the quantifiable data on frequency of use it was decided to select a descriptive approach to the study.

1.7.1 Data collection methods

A questionnaire will be used to collect data from the research participants. The questionnaire will be personally administered and collected from the research participants. The suitability of the questionnaire as a data collection tool comes from its ability to combine both close and open ended question that will give the researcher an opportunity to collect both numerical and thought probing data with a consistent theme.

1.7.2 Data type

Both quantitative and non-numeric data will be collected from the target population to gauge perceptions, identify HIV/AIDS service requirements and frequency of use. Quantitative data collection method is going to be used to collect information from the target population.

1.7.3 Target group

The target group of this research are employees at Company X, City Branch, with more than one year of service. These employees are covered and make use of the employee wellness program which includes HIV/AIDS support services; total population is 100.

Participation will be limited to permanent employees with more than one year of service as they have a greater probability of having made use of external or outsourced services within the work context. Permanent employees with less than one year may not be familiar with the company's employee wellness program as well as they have probably made less frequent use of outsourced or external HIV/AIDS

providers within the context of the working environment. Non-permanent and outsourced staff in the company has been excluded because they do not benefit and are not covered under the workplace employee wellness plan.

1.7.4 Data analysis

Descriptive statistics will be used to analyse the data collected as relevant to determine the frequency and mean variables. Qualitative data will be analysed through content analysis, data coding and labelling in order to gather the meaning of the phenomena described.

1.8 Outline of chapters

The research outline will consist of the introduction in chapter 1. This will contain the background of the study and contextualisation of the research problem as well as highlight its aims, objectives and significance.

Chapter 2 will cover the literature review supporting the research. In this part literature will be viewed including past researches in order to further refine defining the research problem, identifying applicable theory and practices.

In chapter 3 the focus will be on data collection techniques that are part of the research methodology. Elements covered include identifying the sampling method, research design and spelling out ethical considerations that constrain the research study.

Chapters 4 will include reporting and discussion of results.

Chapter 5 discuss the achievement of the aim and objectives within the context of the study. Recommendations and conclusions are provided for the way forward.

1.9 Limitations

The private business entity within which the proposed research is to be conducted has requested anonymity for the protection of its commercial interest. However, access to study participants and any other necessary support has not been limited

by this request. A limitation of the study could be contained individuals have been excluded in only one company will be used for the research. Further only a selected group of employees have been included, however, all the other were left out.

1.10 Conclusion

Corporate business continue to take steps to mitigate the impact of HIV/AIDS on business profitability through HIV/AIDS policy development, there is need for a better understanding of how the perceptions of employees towards outsourcing or externalising of HIV/AIDS services offered have influenced the uptake and use of these services. HIV/AIDS management in the workplace need be to be effective so that VCT, anti-retroviral therapy, and general health care are readily accessible to employees. Although outsourcing of services to independent service providers have the advantages of better confidentiality, reducing possibility of stigma associated with visiting VCT facilities in sight of co-workers, low paid workers [who may not have medical aid to cover HIV/AIDS care] and those who lack self-initiative may find the use of those external services beyond their reach. There is therefore a need to explore the employees' perception towards accessing the epidemic support services outside the boundaries of their working places in order to determine how such perceptions impact on uptake levels of HIV/AIDS support services.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

This section will gather data about HIV/AIDS and review the global, sub-Saharan and organisational patterns of the epidemic. Other specific literature sources are further reviewed to help define and shed more light on the problem of the low use and uptake of HIV/AIDS support services such as VCT and participation in the ART programs for people living with the infection (PLWHA) both in the workplace and in communities so in order to explore this research question. However, although literature on the subject of the low uptake of VCT and ART exist, an observation has been made that limited research has been conducted to explore the relationship between the propensity to take an HIV test in the workplace and the provision of HIV/AIDS support services through a third party or external and outsourced service providers. Much of the research data, which will form the basis of this literature review, incorporates studies and research investigating factors that act as barriers or stimulate individual interest to test with consequent effect on the general uptake levels both in the workplace and communities. While such authoritative literatures do confirm the rate of uptake of VCT remains low despite consistent education and awareness programs to influence positive attitudes to testing and treatment, it would be of interest to HIV/AIDS managers in the workplace to understand how the strategic VCT implementation choices correlate with employee uptake levels.

2.2 Global patterns of HIV/AIDS

In 2013 35 million people globally were living with HIV/AIDS (UNAIDS Fact Sheet 2014). The UNAIDS Annual Report (2008) data shows 2.0 million people died of HIV-related illness and 2.7 million were newly infected in the year 2007. However, new data suggest global HIV/AIDS figures are falling and the impact trend is on the reverse. According to UNAIDS Global Report (2013) the number of people living with HIV/AIDS globally rose to 35.3 million, newly infected people were 2.3 million and HIV-related deaths recorded dropped to 1.6 million in 2012. These figures point towards tangible progress towards the attainment of Goal Number 6 of the 2015 Millennium Development Goals which “calls for unprecedented action to halt and

begin to reverse the AIDS epidemic” (UNAIDS Global Report 2013:2) through improved access to HIV treatment, education about the disease, reducing gender based violence towards women and invested political leadership and action in all countries around the world (UNAIDS World Day Report 2012). However, while such progress is encouraging its negative impact on societies, social relationships, the economy and business corporations persist to be felt. HIV/AIDS patients are crowding out other patients suffering from other ailments in hospitals as their hospital bed occupancy rate continue to rise (Haacker, 2002; Tamiru & Haidar, 2010), each day there is a growing number of child-headed households and “AIDS orphans in sub-Saharan Africa: [who are] a looming threat to future generations” (UN) and role of expectations of businesses in society to provide relief from the epidemic have expanded, particularly in poverty stricken Africa where dysfunctional governments, unstable political climate and health infrastructure deficiencies leave communities vulnerable putting pressure on business corporations to fill in the void (Van Cranenburgh & Arenas, 2012). Globally HIV prevalence ratios have also been shifting from 2001. While Eastern has witnessed a 250% prevalence rise from 2001 to date and in SSA, steady decline has been realised from 5.8 % to 5.0%, with stable margins of 0.3% in South East Asia over the same period (AVERT, 2014). The overall negative impact to date of the disease is seen to be worse than any other infectious epidemic disaster in history (Rosen, Simon, Vincent, MacLeod, Fox & Thea, 2003) and in Africa HIV has taken over from military conflict as the single cause of death (Van Nierkerk, 2005).

2.3 HIV/AIDS in sub-Saharan Africa (SSA)

The plight of people in sub-Saharan Africa to HIV risk is not encouraging. Seventy percent of all PLWH globally are found in this region (Whiteside et al, 2005; WHO [Fact Sheet no. 360], 2014). According to UNAIDS (2014) in 2013 24.7 million of the 35.0 million PLWH globally were resident in SSA, which also accounted for 70% of all new infections in the world and had a paltry treatment reach of 37% to those who require HIV treatment therapy. Consequent to improved access to medication the number of PLWH is steadily increasing (Hontelez et.al., 2012; UNICEF,2014) and so is the entrenchment of moral responsibility to governments and business [and pharmaceutical companies] to save citizens, employees and community lives by actively sponsoring the provision of ART at the expense of profiteering (Resnik,

2005). If ever governments and businesses have been practically willing to invest in programs and action to halt the epidemic in SSA, real evidence is yet to show. HIV/AIDS incidence levels in countries in SSA are still high and worrisome. In 2009 “nine out of ten countries in continental Southern Africa had HIV prevalence rates among 15 to 19 year olds between 11% and 25.9%, the highest worldwide” (Tadele, 2013;7). The mean HIV prevalence rate in South Africa is estimated at 17.4%, Swaziland and Botswana have prevalence rates above 23%. Swaziland carries the distinction of having the world’s highest HIV prevalence rate of 26.1. Other countries in the region fare no better with all carrying prevalence rates between 10% and 15% (AVERT 2014). Lethargic government responses to HIV are patently historical in SSA, most notably the resistance of the South African government to roll out the ART program until it bowed down to pressure from HIV advocacy groups (Scheider & Fassin, 2002; Natrass, 2011). Some current behavioural practices by heads of government such as Swaziland’s King Mswati’s yearly cultural practice of choosing young girls to be his wives or current South African president’s much publicised polygamous marriage help to point towards the utmost lack of exemplary political leadership to tackle the epidemic (Gender Links, 2013).

The response pattern of business to HIV intervention in contrast is still an evolving process. According to Rosen, Feely, Connelly and Simon (2007:S42) in Africa and indeed SSA “the appropriate role of the private sector in fighting the epidemic [moreover] remains an unanswered question in most countries” and many of the businesses have ignored or done little to provide HIV services to their employee and communities. A study by Taylor, DeYoung and Boldrini (2004:2) reveal “globally, nearly half of business executives surveyed recognize some current or future impact of HIV/AIDS on their businesses, but only 6% have instituted written policies”. Findings from a research in Malawi to explore factors barring firms from adopting HIV/AID policies in the workplace identified internal rather than external operating variables as reasons which impacted on policy implementation (Bakuwa & Mamman, 2012). Many of these private companies are instead altering their conditions of employment and outsourcing labour to shift the cost burden of HIV to either employee households or to the government (Rosen & Simon, 2010). In Botswana allegations of pre-employment HIV testing at diamond firms are being made (Africa

Science News Network, Kenya, 2008) and the restructuring of employee death or ill-health redundancy benefit schemes to lower employer contribution have been extensively reported in South Africa. The reality for business in SSA, however, remains one with practically limited choices to evade the costs of the epidemic. “A vast majority of people living with HIV and AIDS in sub-Saharan Africa aged between 11-49 years are in the prime years of their working lives” (AVERT, 2015); the costs of employee absenteeism, loss of production, deaths and related overhead costs directly impacts on any businesses competitiveness giving companies an incentive to invest in programs to manage the epidemic in the workplace (Stop AIDS Now, 2009).

2.4 HIV/AIDS in South Africa

South Africa is a country known to host the highest number of PLWHA in the world (UNAIDS, World AIDS Day Report, 2011). Various data sources estimate figures of the PLWHA in South Africa from 5.1 million to 6.4 million as of 2012 (Sishana et. al., 2012; UNICEF, 2014; SARAH, 2014; Stats SA, 2014). Adult national prevalence rate is 17.8% and in the women age group 34-45 years a prevalence rate of 40% has been reported in some areas. The epidemiology of HIV/AIDS in South Africa bears much resemblance with the rest of Africa and SSA in particular. In defining its context associations between poverty stricken communities and high HIV incidence rates can be made (Tladi, 2012) although other recent researches have made other findings to the contrary (Masanjala, 2007; Fox, 2010).

More women than men are living with the virus and the influence of culture and traditions on sex and health seeking behaviours continue to present challenges in efforts to control the epidemic. Despite rolling out the world’s largest antiretroviral therapy treatment programs for PLWH not all intended beneficiaries are practically able to access the treatment, particularly in rural areas without health infrastructure and poor roads. According to UNAIDS (2010) between only 35-39% percent of people who needed HAART could access it in 2009. In addition HIV-related health seeking behaviour of vulnerable populations is also discouraging. Govender et al., (2011) observed low initiation into a mining company’s ART program even where employees were HIV positive. One out of five people opt to test for HIV in South

Africa even if they are all aware where they can get the services (Sishana & Simbayi, 2002; UNAIDS, 2012).

The role of businesses in coming up with response interventions to compliment governments' efforts has therefore loomed large and the adoption and implementation of HIV/AIDS policies has become a necessity. If no effective action is taken the threat of epidemic to human resources is potentially devastating in South Africa. Elias (2000, as quoted in Dixon, Mac Donald & Roberts: 2001) asserted "in South Africa, for example, around 60% of the mining workforce is aged between 30 and 44 years; in 15 years this is predicted to fall to 10%". The SABCOHA (2014) projections raise figures of 10% to 40% as potential number of employees who are living with the virus at each particular workplace. Consequently most large businesses and multinational companies have taken the lead in providing HIV/AIDS services in the workplace including VCT, HIV education and training campaigns and the provision of ARVs while PMCT is rarely offered. It is mostly within companies which have traditionally offered onsite health centers such as mining firms where ART is offered. In other workplace situations companies assist employees to access HIV services offsite at public health centers such as hospitals or private clinics. Companies will either pay or not pay for employees to access these services and some incorporate the use of employee wellness programs nominated service providers to treat their employees. Alternative methods to improve service accessibility for populations in the workplace have used the mobile health clinics which are invited on specific days to allow employees to test for HIV, receive counselling and receive education.

2.5 Models of workplace HIV/AIDS interventions in South Africa

Connely and Rosen (2005) observed four categories of how businesses have shaped the way they manage HIV/AIDS in the workplace to contribute to maintaining employee welfare and promote access to HIV/AIDS services. Based on research result from a study done in Zimbabwe, Scot et al. (2013) identifies an additional approach to the list which they term 'employer assisted public provider or hybrid model'.

Connely and Rosen's (2005) classified models:

Model 1: Employer Provider – here the employer takes responsibility to finance and provide treatment and care in the workplace for employee and family.

Model 2: Medical Scheme – initiates a co-payment option to subsidize employee medical scheme cover to promote access to HIV/AIDS services.

Model 3: Independent Disease Management Program (IDPM) – responsibility to manage costs, treatment and care of employees living with the virus is ceded to a contracted IDPM.

Model 4: Clinic Provider – where an outside HIV/AIDS treatment and care provider is contracted to render service to employees either onsite or an external clinic.

Model 5: Employer assisted public provider: where “the employer assist workers in in accessing treatment from public hospitals generally through encouraging visits and providing transport” (Scot et.al 2013:10)

However, whatever model has been applied in the workplace to date the behavioral response of employees towards uptake and use of these services has been discouraging. This observation has informed the design of this research which seek to understand how perceptions and attitudes towards having access through external service providers has contributed to the low uptake of services in the workplace.

2.6 Scholarly review on uptake levels of HIV/AIDS services in the workplace

Existing literature has been able to identify structural, personal and social influences on HIV/AIDS testing behaviours in the workplace. A survey carried out in Kenya, Inrugu, Varkey, Cha and Patterson (2008) found there was a positive correlation between convenience and accessibility of VCT to an individual’s willingness to test for HIV/AIDS. According to this finding, in a situation where VCT services are found onsite there would be a greater likelihood that employee’s uptake and use of the VCT facilities is bound to be high because of ease of accessibility and convenience. However, Mahajan, Colvin, Rudatsikira and Ettl (2007:S35) offer a different thought and argue where onsite VCT services are promoted “one among many factors limiting the success of voluntary HIV testing is distrust of an employers’ motivation to

conduct testing". They go further to highlight the negative impact of workplace social practices such as stigma and discrimination on health seeking behaviour of employees in the workplace resulting in low uptake of VCT and ART programs in the workplace. Mahajan et.al., (2007) are able to underline that perceptions towards employee VCT in the workplace testing and uptake of employer initiated programs can emanate from factors such as fear of retrenchment and perceived legality of the testing program.

Further appreciation of the influence of structural factors on health seeking behaviour related to where and how HIV/AIDS support services are provided to employees exist in literature. In a study done by Fylkesnes and Siziya (2004) in Zambia it was established the general perception of the individual employee of the health services on offer acted as a barrier to testing. They further highlight because 'people seem to place high value on privacy' an assurance of confidentiality plays a bigger role in influencing individuals to accept to be tested. Mundy and Dickinson (2004:174) also posit employees are not willing to be tested in the workplace as a result of perceived hostility emanating from other employees, supervisors or the employer. The extent to which these personal and perceptual factors sum up the desirability of providing HIV/AIDS support services through external agents such as public health facilities, private hospitals and mobile HIV/AIDS testing in communities becomes the interest of this research.

In focus group research conducted in the United States to investigate perspectives towards HIV testing in non-health care settings such as mobile VCT or workplace based testing centres Joseph, Fasula, Morgan, Stuckey, Alvarez, Margolis, Stratford and Dooley Jr (2011) established concerns about perceived lack of privacy, confidentiality and negative beliefs about the professionalism of staff rendering VCT services as negatively impacting on the level of VCT uptake. These findings are confirmed in a more recent research done in Kenya wherein Museve, George and Lobongo (2013) are able to identify the quality of service, the location of the VCT centre and its overall appearance as relevant factors to uptake and use of VCT services in a community.

The effect of stigma, discrimination and social relationships on VCT uptake in the world of work has also been subject of interest among researchers. Arimoto, Ito, Kudo and Tsukada (2013:2) indicate while able to enforce a credible ground for the desirability of workplace based VCT programs by recognising when “compared to VCT at distant public clinic offering HTC at a company onsite clinic may also induce uptake by reducing both material and emotional burden of receiving the test”. Due to the ease of accessibility and deliberate encouragement by the employer to test, they also underline the closed community in the world of work is such that fear of discrimination and consequent stigmatisation by fellow employees acted to deter individual employees from testing. They further argue the desire to preserve an individual’s social utility among other employees discouraged employees from testing fearing that a positive serostatus will result in them losing social contacts as a result of stigmatisation. The impacts of social relationships on VCT uptake were also explored by Joseph et. al., (2011) who found although conveniently located VCT facilities in local communities [workplaces] were welcome individuals expressed great anxiety about being seen going to a testing centre with others travelling to other communities where they are unknown where their privacy is protected. In context a randomised trial participation study conducted in Harare by Corbett, Dauya, Matambo et al., (2006) also demonstrated the importance of convenience and accessibility in influencing uptake of VCT services among employees at work. The study results showed the mean uptake for onsite VCT was 51% while the off-site rate was 19.2%. Nonetheless, it has been cautioned results of this study do not conclusively support it is best to offer VCT services onsite than offsite as the uptake rates may suggest. Scott, Campbell, Skovdal, Madanhire et al., (2013) remarked it is a complex issue to be definitive as to whether onsite or off-site VCT will yield better results than the other.

It has been indicated in African communities where culture and tradition still undermine the rights and roles of women in marriage there are real constraints for them to have access and use of VCT, condoms or HIV/AIDS educational programs. A study done by Mwale (2014) in Malawi found because women fear divorce, labelling and cannot negotiate with their husbands for spousal VCT or condom use their uptake of HIV/AIDS support services is limited. Apart from reaching similar conclusions Mbonu, den Borne and De Vries (2009) observed gender inequality,

religious beliefs, partner's attitude towards VCT and the element of male domination in sexual relationships impacted on women's negative participation in accessing ART services or use of condoms, more so in poor communities. It can be said the positive element resultant from onsite work-placed based HIV/AIDS support services such as ART, VCT and treatment for sexually transmitted diseases is to liberate vulnerable women from social and cultural constraints associated with gender inequality.

Further insight into the behavioural patterns of use and uptake of the VCT is contained in an analysis of the role of the private health providers in HIV testing by Johnson and Cheng (2014). They established men use private HIV test providers more than women even after discounting the ante-natal counselling visits when women are pregnant. These findings probably indicate availability and ease of access that workplace based VCT programs provide have little impact to improving uptake of HIV testing onsite among men who are more concerned about anonymity, privacy and perception of quality of the service. Further studies have shown the VCT utilisation levels are more with women than men (Anderson and Louw-Potgieter 2012; Subramian et al., 2008). WHO/UNAIDS/UNICEF (2007:48) had earlier observed "social factors such as individual attitudes and personal perceptions of risk also have a considerable effect on the uptake of VCT" and reiterated that negative reactions following disclosure of test results also act to discourage individuals, especially men from willing to test and know their status.

Employees wanting to know their HIV/AIDS status, the provision and access to treatment in the event they are HIV positive is an important consideration whether or not they will use company sponsored on-site HCT services or make use of external service providers such as private clinics and public hospitals. Govender, Akintola, George, Petersen Bhagwanjee and Reardon (2011) explored the relationship between availability of ART and testing established attitudes favourable towards ART served as motivation for individuals to test. Phakathi, Van Royen, Fritz and Ritcher (2011:177) are in support in their own study where "equally affirming was the strong, motivating and hope-inducing role that ART played in encouraging individuals and communities to test for HIV". In South Africa, evidence in support of this can be seen from the comparison of HIV test uptake levels between companies in the

mining industry and other industries. Most mining company workplace HIV/AIDS programs provide for access to ART and their commitment to its management is more intense than in other industries such as retail, where basic related education and awareness programs, wellness day events and ad hoc VCT service providers can be hired to give employees access to the services.

2.7 Conclusion

The problem of low utilisation of HIV/AIDS services pose a serious challenge to global and local efforts to control the spread of the epidemic. If a tangible progress is to be realised behavioural tendencies to promote seeking behaviour of individuals need to be reinforced. In South Africa, the number of people who test for HIV/AIDS is low, enrolment into public health or company sponsored ART programs is still minimal and stigma and discrimination towards PLWH is being practiced. The challenge to develop programs and evaluate the effectiveness of current programs is therefore necessary as part of a revolving process which seek to effective methods of managing HIV/AIDS. This research aims to explore the contributions of relying on external HIV/AIDS provision and the how attitudes of employee towards these service providers impact on their uptake patterns. Results from this study will give an insight into the propriety of creating external partnerships when managing HIV/AIDS in the company and the influence of attitudes and knowledge to usage levels

Literature review focussed on the epidemiology of HIV/AIDS at global, SSA and South African context. Findings and research data from scholarly articles on the general scope of low uptake of HIV/AIDS services has been looked at to explore reasons why low incidences of HTC, enrolment into ART programs and non-clinic attendance is becoming a characteristic element of the problem of HIV/AIDS management.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 Introduction

This chapter outlines the methodological framework guiding the research study. It elaborates on the research design and research methods to collect data and interact with the research participants, the description of the target population, sampling method and explain how research ethical standards and requirements are met. According to Kothari (1990:8) the scope of methodology has a wider dispensation from not only elaborating on research methods but also “consider the logic behind the methods we use in the context of our research study and explain why we are using a particular method or technique”. In abstract sense methodology is the operational guide of a research process which seek to find meaning in a human phenomenon. This aids to formulate a better interpretation and understanding of the research outcomes by both the researcher and third party recipients who may uses this data. The problem is thus: How do the perceptions of employees towards outsourcing or externalising of HIV/AIDS services influence the uptake and use of these services? The objectives of the study are:

- To establish employee experiences when accessing HIV/AIDS support services at external service providers
- To investigate on the frequency of use of outsourced HIV/AIDS programs
- To establish individual preferences on where to access HIV/AIDS services
- To provide guidelines for organisations to face reality

3.2 Research setting

This investigation into attitudes and perception towards outsourced HTC services in the workplace was conducted in a retail workplace setting. As observed in South Africa except of the mining industry, business activism and consequently employee enthusiasm towards HIV/AIDS programs in other industries is rather lukewarm and this directly feeds into the merits of any research related to the epidemic in those industries. However, in this research landscape some evidence of HIV/AIDS policy initiatives were observed. Male and female condom dispensers are present inside their bathrooms. Colourful posters advising on how to access telephonic 24-hour HIV

related counselling and employee wellness services through a company nominated service were seen in the canteen place. Access to HTC is also provided through mobile testing units which occasionally visit the workplace. The existence of practical bias segregating non-permanent employees from being covered under a company sponsored wellness program is noted as an example of the characteristic poor HIV/AIDS practices found in most businesses in South Africa.

3.3 Research approach

The type of research data to be gathered determines the research approach to be taken. In order to gather perceptual and behavioural data to describe the attitudinal phenomenon towards outsourcing of HIV/AIDS services a qualitative approach was chosen; qualitative research gives results quantitative methods cannot. Quantitative approach emphasises the use of statistical methods to collect and interpret data. Such data is collected using a questionnaire with close ended questions to allow for mathematical manipulation. In qualitative research approach data gathered is often non-numeric and not amenable to statistical interpretation. According to Strauss and Corbin (1990:11) the hallmark of classifying qualitative analysis lies not in possible “quantifying of qualitative data but rather to the nonmathematical interpretation carried out for the purposes of discovering concepts” and building the capacity to form theories of explaining the phenomenon. While the semi-structured questionnaire used in this research also gathers quantified behavioural data, it is the philosophy of interpretation which records the data to describing the attitudes to outsourced HIV/AIDS services which binds the procedure of enquiry as a qualitative research. They (Strauss & Corbin) also draw attention to the role individual temperament and orientation impact on research approach chosen. In qualitative research the role of the ‘self’ as a research instrument is often highlighted and the criticism of bias associated with being personally involved with the subjects and phenomena potentially raise ethical questions (Terre Blanche & Kerry, 2004). While the challenge is a practical one the researcher undertakes to deploy the ‘self’ as a passive participant to the process to the extent capable of facilitating the administration of the data collection and decoding process. The purpose of a qualitative research is to socialise with the human subjects in their natural setting to develop an understanding of their phenomena.

3.3.1 Research design

A study design elaborates on the plan used to gather data to describe or draw conclusions on the issue being investigated. Christensen et al., (2014) conceive a research design as a procedural plan of data collection and analysis. Kothari (1990:27) views a research design as “the conceptual structure within which research is conducted; it constitutes the blueprint for the collection, measurement and analysis of data”. A survey research design which “attempts to describe and explain conditions of the present by using many subjects and questionnaires to fully describe a phenomenon” will be employed by this project (Caroll, 2014) was employed to guide the process of investigating perceptions of employees towards the use of external HIV/AIDS services. Given the perceptual and behavioural focus of the research question a descriptive research design was seen as appropriate because of its ability to create findings which are capable of generalisation.

3.3.2 Data collection methods

A questionnaire was used as a survey instrument to gather data from the sample population. The semi-structured questionnaire included both open-ended and close ended questions so that both numeric and non-numeric data could be collected. According to Taylor-Powell (1998:5) open ended questions are necessary as they allow respondents to give their own answers and “the opportunity to express their own thoughts but also requires some efforts in terms of their responses” Data collection using a questionnaire is suitable for research dealing with sensitive and personal subject such as HIV because it removes the social bias the researcher might impose on the participants as in a personal interview situation. It also allows the researcher to control the answers participants can give for ease of data analysis and coding. Survey methods rely on use of questionnaire as they can be distributed to a wider number of participants to increase the reliability and validity of research findings.

3.3.3 Questionnaire administration

Self-administration of the research instrument was chosen as an effective method to contact participants because of the need to discriminate between employee who qualified to participate in the program and those who did not. Although the study

aimed to investigate workplace HIV/AIDS services utilisation behaviours and employee perceptions the study limitation focussed on those permanent employees who were covered under the company wellness program. It was therefore necessary for the status of potential participants to be determined before questionnaires were handed out for participation.

3.3.4 Study population

According to Cox (accessed 2015) “target population defines those units for which the findings of the survey are meant to generalise”. It refers to the total number of subjects to which the survey data will relate. This research sought to study the demography of this population that is composed of adult men and women employed in a retail business set up in Cape Town. Representative gender balance was pursued through purposive sampling to recruit equal numbers of male and female respondents for participation.

The target group are employees at Company X, City Branch and Cape Town with more than one year of service. These employees are covered and make use of the employee wellness program which includes HIV/AIDS support services; total population is 60.

Participation was limited to permanent employees with more than one year of service as they had a greater probability of having made use of external or outsourced services within the work context. Permanent employees with less than one year may not be familiar with the company’s employee wellness program as well as they have probably made less frequent use of outsourced or external HIV/AIDS providers within the context of the working environment. Non-permanent and outsourced staff in the company has been excluded because they do not benefit and are not covered under the workplace employee wellness plan.

3.3.5 Sampling

Sampling refers to the method of choosing the representative group from the total population being investigated. When effectively done sampling comes up with an adequately representative subset of the total population. In this study a purposive sampling technique was applied to select the sample group. “Purposive sampling,

one of the most common sampling strategies, groups participants according to preselected criteria relevant to a particular research question” (Family Health International Guide: undated). Accordingly it is a suitable approach in this research for two main reasons: allows the researcher to be able to discriminate between employees who satisfied the exclusion (permanently employed for one year) criteria and those who did not and gives the latitude to determine the number of participants on a theoretical basis (Family Health International Guide: undated).

3.3.6 Data type

The questionnaire research contains both open-ended and close-ended questions to capture both quantitative and non-numeric primary data from the target population. Primary data is derived from original research and appertain to the question at hand. However both data responses are coded in a way which allow for the application of statistical application during data analysis.

3.3.7 Data analysis

Descriptive statistics will be used to analyse the data collected as relevant to determine the frequency and mean variables. Qualitative data will be analysed through content analysis, data coding and labelling in order to gather the meaning of the phenomena described.

Survey research involves asking a large sample of participants’ questions through an interview or through a written questionnaire. The advantage of survey research is that it is a relatively quick way to gain large amounts of data from a sample. This data is easy to process and quantify. However, a researcher has very little control over the people who are involved in the survey and cannot eliminate many of the variables that could influence the results of the survey. Conducting a survey on personality there could be a particular personality type that would be predisposed to filling out the survey and sending it back. This personality type would then be overrepresented in the results of the survey. Social desirability bias is where people often give answers that are politically correct even if they do not personally agree with the answer.

3.4 Conclusion

The methodological framework has set the parameters within which the research is to be conducted. A retail work environment with minimally visible epidemic control efforts like the provision of condoms in dispensers or access to telephonic counselling has been defined. Qualitative research approach is chosen to guide the implementation of the survey design to be carried out. Data is collected from a sample population of (30) thirty permanently employed staff. Much of the data collected is qualitative in nature and fits well with the use of descriptive statistics to find meaning and ideas from the data

CHAPTER 4

RESEARCH FINDINGS

4.1 Introduction

This chapter will report on the results of the 30 interviews successfully conducted with the study participants at a retail workplace in Cape Town. These findings reflect on each aspect of the investigation as addressed in the research questionnaire in a way that would facilitate an easier interpretation of general employee attitudes towards outsourcing of HIV/AIDS services in the workplace. Data presentation techniques used includes graphs, pie charts, tables and statements to communicate data gathered in a clear manner.

The problem statement of the study is: How do the perceptions of employees towards outsourcing or externalising of HIV/AIDS services influence the uptake and use of these services? To gain a solution to the problem the objectives are:

- To identify HIV/AIDS support services employees require
- To establish employee experiences when accessing HIV/AIDS support services at external service providers
- To investigate on the frequency of use of outsourced HIV/AIDS programs
- To establish individual preferences on where to access HIV/AIDS services
- To provide guidelines for organisations to face reality

4.2 Demographic data of participants

A total of thirty (34) employees participated in the research. Questionnaires from thirteen (13) male (43%) and seventeen (17) female (57%) participants presented valid data which make up these findings. The other four questionnaires were rejected on analysis because they did not provide useful data. The research plan initially targeted to interview forty (40) individuals in the company.

4.2.1 Gender Participation Analysis

Figure 4.1
Gender Participation

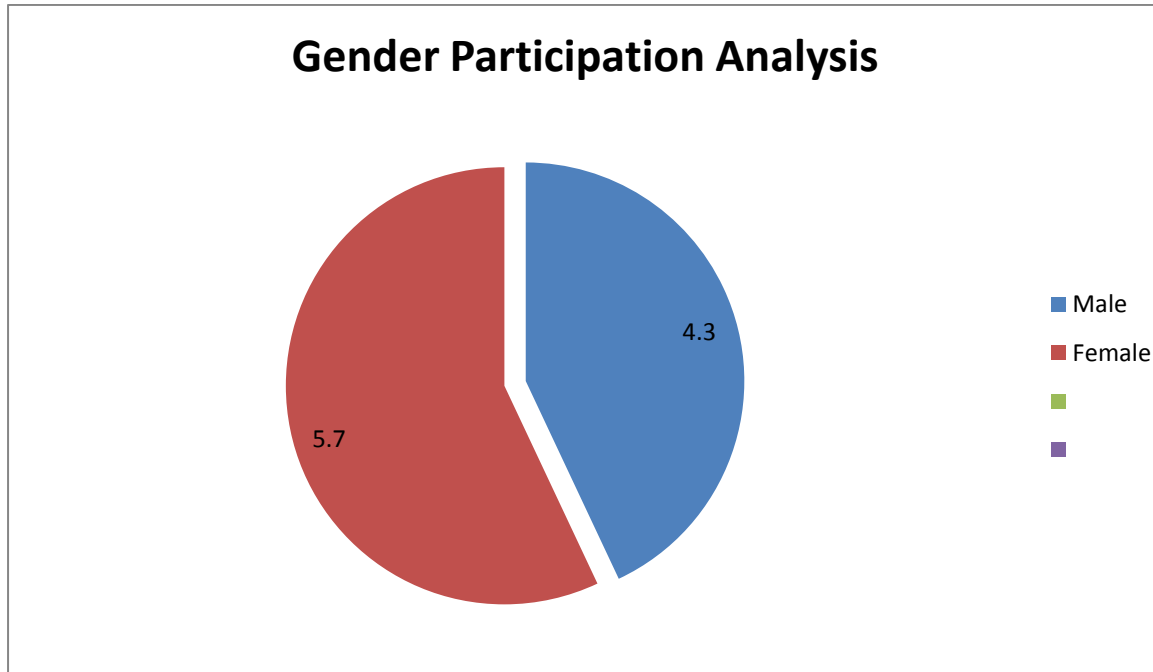


Table 4.1
Age Analysis

Age Category (Years)	Frequency (n)	Percentage (%)
18-24	3	10
25-34	12	40
35-45	13	43
45 and above	2	7
Total	30	100

The demographic data show 83% (figure 4.1) of the employees working in the company is aged between 25 and 45 years (table 4.1). Individuals in this group are known to be the most sexually active and have a greater demand for HIV/AIDS services compared to other age groups. The youngest participant is 23 years (male) while the oldest is 46 (female).

4.2.2 Desired Employee Health Services in the Workplace

This question sought to explore the kind of employee welfare and HTC related services employee desired to access within their work environment. The total thirty (30) responses; ten (10) participants preferred not to indicate what services they would prefer to be provided in the workplace. However, the desired on-site employee welfare services were found to be:

- Counselling
- Tuberculosis (TB) and blood pressure (BP) testing
- Nutritional information
- Diabetic testing
- Clinic

A notable observation from the responses was no direct reference to the need for HIV testing in the workplace was given by all respondents. TB testing and counselling were the most commonly desired services followed by high blood pressure monitoring. While TB testing and counselling are closely associated with HIV/AIDS, the demand for high blood pressure monitoring services may be seen to suggest the presence of high stress levels in the workplace.

4.2.3 Necessity of an HTC in the workplace

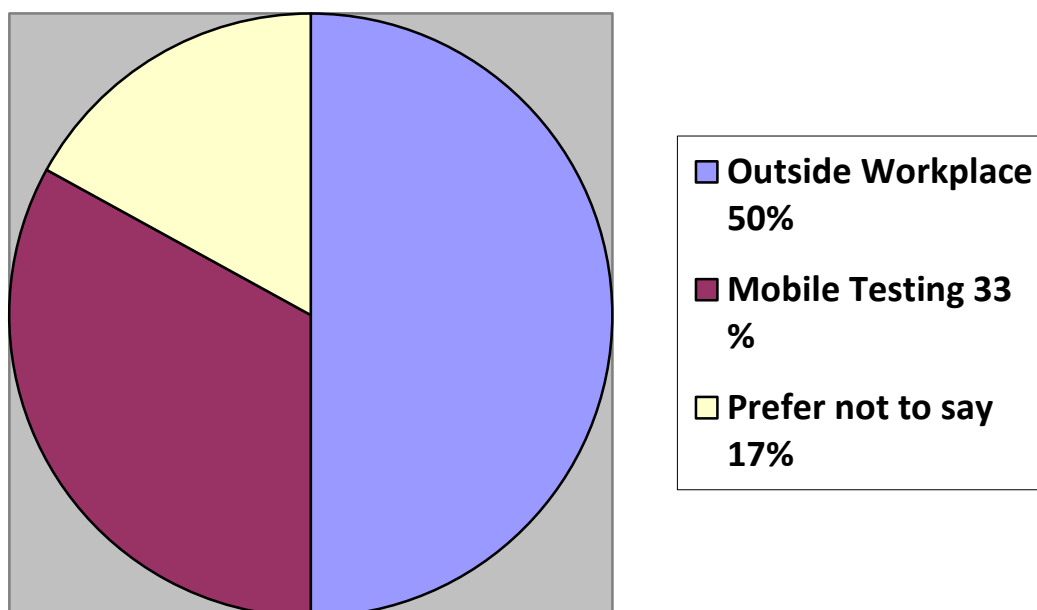
The challenges of HIV/AIDS as a public health concern has promoted a holistic interventionist approach which has emphasised on the need to make HTC services widely available and hence the ideas to provide such services in the workplace have been entertained. However, with reported low utilisation of HTC services being described from existing literature and the desire to understand why employees do not utilise these services as expected, an opportunity is left to probe whether employees see it necessary for them to be provided HTC services in the workplace. This part of the questionnaire sought to establish the readiness of employees in the workplace to accept HIV/AIDS testing in the workplace based on their perception of its necessity to be provided in the workplace.

Results show ninety four (94%) percent (28) participants think having an HTC service facility in the workplace is a necessity. The other six percent (6%) believe the

contrary. These findings assist in rationalising the importance of improving employee welfare programs to include HIV/AIDS services and redirecting focus to institutional and personal factors underlining the slow low utilisation of existing HTC services in the workplace.

4.2.3 Testing site preferences

Figure 4.2
Site Testing Preferences



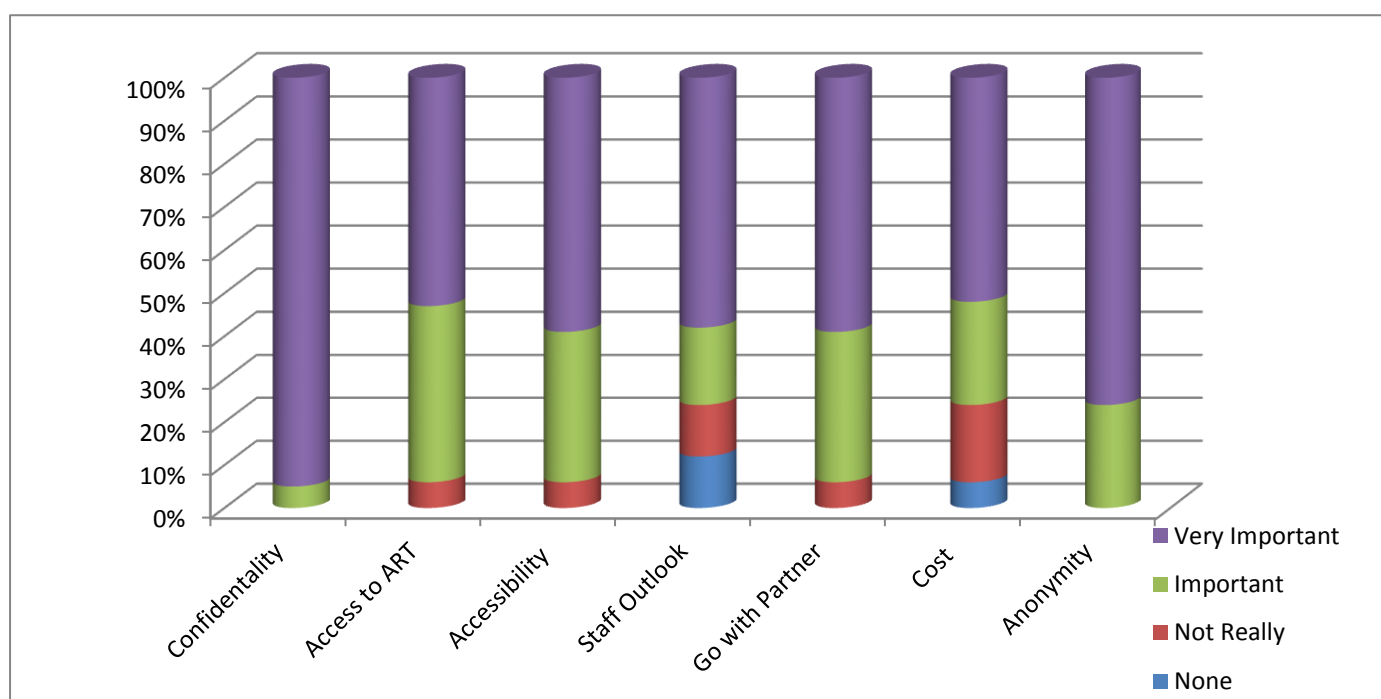
This question followed up on 4.3 to determine consistency between employee desire for HTC services in the workplace (HIV testing) and where they would actually go for such services (figure 4.2). Whereas 4.3 sought to indicate the behavioural desire to utilise HTC services in the workplace, 4.4 measured the rate of actual utilisation. Figure 4.2 shows 50% of the employees would opt to use services outside the workplace, 33% would opt for mobile testing centres that come to the workplace while 17% elected not to respond to this question.

Data was also analysed to determine gender based differences to choices for accessing HIV/AIDS services. More women (60%) compared to 20% men were found to be willing to use on-site HTC facilities.

4.2.5 Measuring the influence of social and environmental factors to choice of testing facility

Figure 4.3 contains a summary of participant employees' response to the question: When deciding on where to go for HIV/AIDS test/Counselling/how important are the following elements in shaping your choice? Employees use a rating from 1 (none-not important), 2 (not really important) 3 (important) and 4 (very important) to judge how each of the seven (7) listed factors influence their choice of HIV testing site.

Figure 4.3
Influence of Social/Environmental Factors



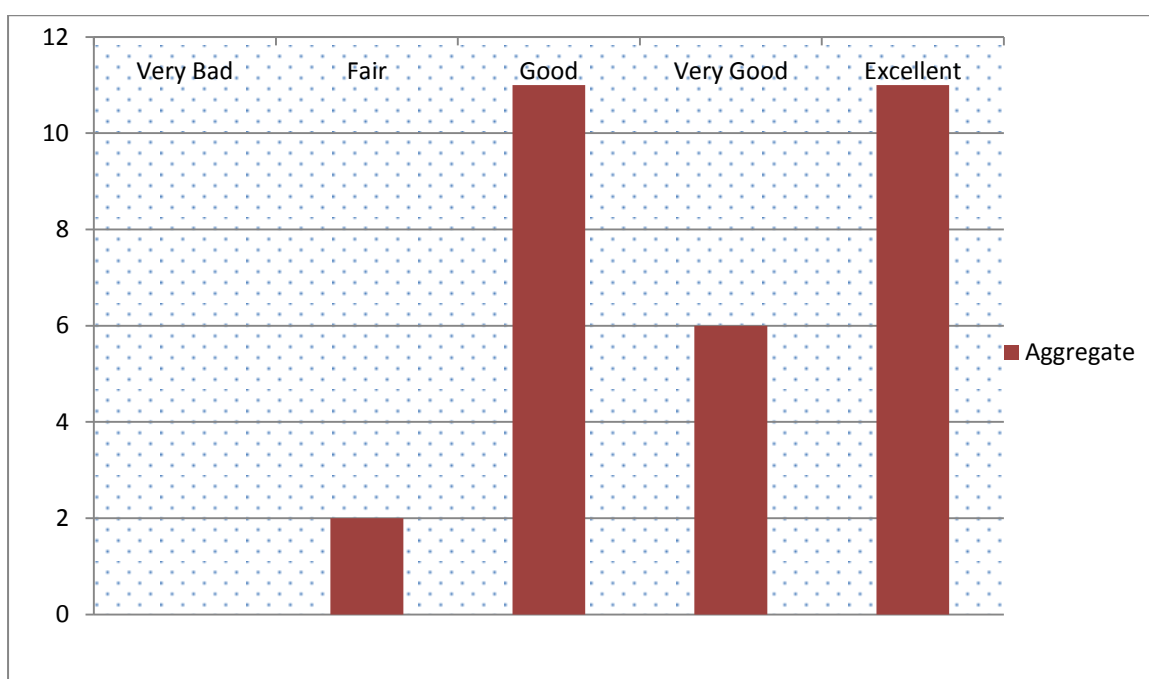
An analysis of figure 4.3 shows confidentiality and anonymity as having the greatest impact in influencing employee choices of where they will choose to access HTC services. The majority (95%) of participant employees rated confidentiality as being important with 83% for anonymity (desire for privacy). The importance of confidentiality and desire for privacy (anonymity) has been underscored in other researches. Mooeketsi (2014) came to similar findings in a research investigating factors preventing the uptake of HTC at Industrial Development Company in Johannesburg wherein a close association between confidentiality and privacy with HTC uptake was made. The pattern of data in figure 4.3 shows access to ART,

improved accessibility, staff outlook, ability to go with partner and cost considerations as factors without higher range of 'very important' when individuals decide on where to access HTC services across many employees.

4.2.6 On a scale of 1–5 (1 = very bad, 2= fair, 3=good, 4=very good, 5 = perfect) how do you rate external HIV/AIDS service providers (public clinics, private doctors) on the elements in Question 5?

Figure 4.4

Rating of External HTC Service Providers by the Employees



Results to this question (figure 4.4) reveal an overall strong rating of external HTC service providers from 3 (good). The 30 respondents; only two (2) individuals rated these service providers below a score of 3. Six (6) participants rated the services at 4. Eleven (11) participants gave a score of 3, the same number as those who found external service providers to be excellent (5). These results show aggregate opinions of employees towards external HTC service providers to be positive.

Although the results do account for each individual factor's contribution to the overall score, results in this question assist in identifying key choice comparative factors. A perception of better prospects of confidentiality and anonymity away from peers

seem to play a leading role in shaping positive attitudes towards external service providers. The desire to keep individual HIV/AIDS employee concerns from the workplace and fellow employees is present in existing HIV/AIDS literature. (Corbett, Dauya, Matambo et al., 2006; Fylkesnes & Siziya, 2004). In a research conducted in Zambia by Dieleman, Biemba and Mphuka (2007) on impact of HIV/AIDS on health care employees the findings revealed “HIV-positive health workers remained ‘in hiding’, did not talk about their illness and suffered in silence” (Abstract). Although threats of being seen and stigmatised exist with the use of public health centres, the prejudice to daily relationship with other employees as a result of a known positive HIV status is grossly unbearable. This fear is real as one respondent elaborated on why perceived barriers to testing in the workplace:

“They are afraid of being diagnosed with HIV at the workplace because they won’t be able to control themselves. So it will be obvious to other employees”

4.2.7 Reaction to peer HIV/AIDS status discussion

The question sought to probe on individual likely response having his or her HIV/AIDS status being discussed by others. The motive was to have insight into how participants felt comfortable within their workplace to talk about their HIV status (table 4.2).

Table 4.2
HIV/AIDS Status

Likely Response	Frequency	Percentage %
Disappointed	10	33.33
Don’t Care / Do nothing	5	16.67
Confront them/ Report to management	15	50

The most likely response to being a victim of HIV/AIDS related gossip was confrontation or reporting to senior management. This finding indicates how highly sensitive the subject of HIV/AIDS is in the workplace. It also adds to understanding to how intolerant employees are to being open to others in the workplace are about their HIV status. Only 16.67 % of the employees sampled professed to no reaction

and lack of care. 33% would feel disappointed. These results show how HIV/AIDS leaves employees uncomfortable in the workplace and suggest

4.2.8 Statement responses to whether they agree or disagree with the following statements

Table 4.3
Responses

Question	Agree	Disagree
Most employees would prefer to test away from the workplace	26	4
The employer will gain access to my HIV information if I test in the workplace	18	12
I feel secure to consult about HIV/AIDS at public centres than I would at work	21	9
It is more private and confidential to test at work than at a VCT centre at clinic	10	20
If the company could provide ARVs here I believe many employees would be willing to test on-site	21	9
If other employees could see me taking condoms from the dispensers I would immediately stop.	2	28

Table 4.3 present the nominal numbers of how many of the 30 employee respondents agreed or disagreed with each given statement. In particular the data show more employees prefer to test outside the workplace, feel more secure to test at public health facilities and believe the employer possess the ability to breach HIV-related information confidentiality. Employees also draw a possible relationship between the provision of ART at the workplace and stimulation for more employees to test; two out of thirty respondents.

4.2.9 Why people do not test even given assurance of access to treatment

This question discounted the desire for treatment as a contributing factor to non-testing so identify other critical factors can be identified. In summary the following behavioural related factors were identified:

- Because of fear and what people will say about them
- Ignorance
- Stigmatisation
- Many people when they hear HIV/AIDS they think of death
- Ashamed
- They are shy to go for testing
- People are scared. They do not want to know their status
- They are afraid of people's judgment and opinions about them
- Because people at work will judge them and give them different treatment
- Men and mostly youth- suggestion was that men and youths resist to test more than other groups

These reasons identify key personal, social and prejudices which discourage testing in general.

4.2.10 Identified barriers to testing accessing HTC services externally

Employees often have difficulties in accessing HTC services, especially those located outside the workplace. This question sought to probe on the perceived barriers contributing to limited access to external HTC services. Included is the summary of barriers identified:

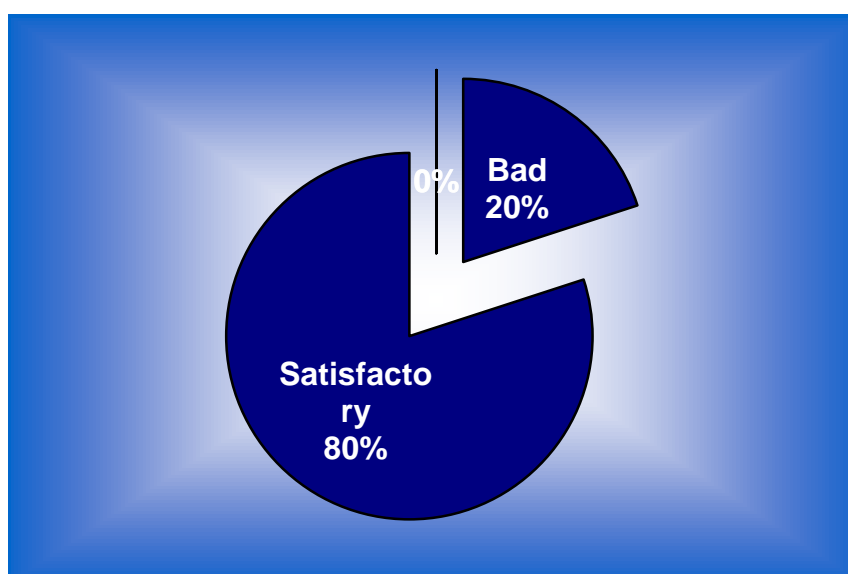
- Perception of no privacy
- Fear of stigma - (people get sick and do not tell because they do not want to be known and end up leaving their jobs)
- They do not want to be seen when they are diagnosed
- Time factor and some do not know where to get tested
- Every month you have to go for treatment and it interferes with your work
- *"They are afraid of being diagnosed with HIV at workplace because they won't be able to control themselves. So it would be obvious to other employees"* (respondent?)
- Accessibility to medication is not guaranteed.
- Lack of convenience

However one participant responded there were no barriers at the workplace.

4.2.11 External health service provider rating

Figure 4.5 shows the service rating approval of external health services experienced by the participants. The total 30 participants surveyed; only 2 rated their last service received as bad. Twenty eight rated the services from satisfactory to excellent.

Figure 4.5
External Health Provider



The inconsistency between the HTC desire level and the probable utilisation level indicated in remains one of the main challenges of companies face when they are measuring the economy of internalising HTC services. While good HIV/AIDS practices would recommend increasing accessibility of HTC services by internalising them the low utilisation levels experienced make very little case for commercial entities.

4.3 Conclusion

Research findings provide an overview of relevant factors unearthed with respect to the current problem being investigated: how do the perception of employees towards outsourcing or externalising of HIV/AIDS services influence the uptake and use of these services. Data collected from the 30 participants reveal more women (57%) compared to 47% men participated in the research with an overall 83% of all

participants aged between the age group 25-45 years. No direct reference to HIV/AIDS testing services was made when employees listed employee services they require in the workplace although 94% agreed it is necessary to have HTC services in the workplace. Potential uptake levels of internally provided HTC services is found to be low compared to how employees tend to utilise services outside the workplace such as the public hospitals or clinics. Data collected also provides an assessment of the influence of social and factors to choice of testing site, with the desire for privacy and fear of stigma in the workplace emerging as important factors influencing testing behaviour preferences. An overview of barriers to testing also avail and participants rating service quality experience at external service providers indicate general satisfaction by most participants.

CHAPTER 5

DISCUSSION OF THE FINDINGS

5.1 Introduction

This chapter engages in a discussion of the research findings in the context of the research objectives. The aim is to explore the extent to which the research outcomes have helped in answering the research question and gave an enlightened understanding of the stated objectives.

The problem statement of the study is: How do the perceptions of employees towards outsourcing or externalising of HIV/AIDS services influence the uptake and use of these services? To gain a solution to the problem the objectives are:

- To identify HIV/AIDS support services employees require
- To establish employee experiences when accessing HIV/AIDS support services at external service providers
- To investigate on the frequency of use of outsourced HIV/AIDS programs
- To establish individual preferences on where to access HIV/AIDS services
- To provide guidelines for organisations to face reality

5.1.1 Identifying HIV/AIDS support services employees require

This study has identified counselling, diabetic, TB and high blood pressure testing and nutritional information as some of the welfare support services employees require in the workplace. The need for an onsite clinic or HTC service facility for daily health support services has also been uncovered. In one study conducted in Tanzania to investigate employee and employer perceptions towards health and social support services to HIV/AIDS infected individuals “employees named treatment and nutritional support and soft loans and reduced workload respectively, as the most important health and social supports they needed from their employers” (Kassile, Anicetus, Kukula and Mmbando (2014). While the provision of treatment support and counselling services have often been emphasised as core epidemic interventions in the workplace, the demand for nutritional support as observed in this investigation and other studies call for a review of biomedical centred employee welfare schemes often implemented in the workplace. The epidemic has grown over

the years and employees have gained a better understanding of the importance of a good lifestyle and the role of nutrition as part of a holistic treatment regime for the infection as a result of widespread HIV/AIDS educational efforts and experiences with other PLWHA. Vulnerability to food shortage is a reality to most people living with the epidemic and the low salaries and lack of time outside work compounds the nutritional challenge for other employees particularly in resource scarce communities (Gillespie, 2008). Accordingly the package of employee welfare requirements needed for positive impact is no longer limited to medical assistance but also to economic and social needs.

It is also important to note, although employees did not make a direct reference to the need for HIV testing services the desire for on-site clinical services suggest it is for such purposes. This fact can also be supported by individuals' the tendency to correlate the testing of TB with positive HIV infection. Conceptually this behaviour is consistent with denial where individuals do not want to know their status or are rather unprepared but wish to retain a sense of psychological comfort from guessing what TB test results might mean to the own HIV status. In this study fear of knowing one's status has been confirmed as a reason why other employees do not test for HIV/AIDS. In Jürgensen, Tuba, Fylkesnes and Blystad (2012) "when asked why they would not go for VCT, informants reported a general fear of knowing their status, although they knew that people could live for long periods with treatment". A similar observation was made in Govender et al., (2011) where the desire to know one's HIV status provided the least motivation for participating in the on-site HIV testing programs compared to other reasons as the reward of a T-shirt after participation and peer influence. Much HIV-related literature is replete with these findings as well and the challenge to provide employees supports services in the workplace should be tackled within an understanding of potential barriers to testing if such investments are to make a meaningful contribution to employees' lives.

5.1.2 To establish employee experiences when accessing HIV/AIDS support services at external service providers

It was a key objective of this research to gather an overview assessment of the desirability of external service providers of HIV support services through individual

experiences analysis. Findings reveal 94% of the respondents reported a positive experience of these external service providers with a marginal 6% having reported to have negative experiences. It is important to interpret these findings within the comparative framework of this study where respondents are consciously or unconsciously making comparisons between on-site and external service experiences. Preference by individuals to access HIV/AIDS testing services rather than stand-alone company provided facilities seem to be patently true as “attendance at free-standing HIV testing sites appears to be declining plausibly because clients prefer to access HCT services within health facilities” (Njau , Ostermann, Brown, Muhlbacher, Reddy and Thielman, 2014). As findings of this research suggest it is the perception and felt experience towards privacy and confidentiality which external service provide better than on-site clinic or company sponsored mobile testing centres employees’ which play a leading role in measuring site satisfaction levels.

The perception of risk and fear of losing a job and becoming a victim of stigma and discrimination in the workplace associated with on-site testing facilities make sufficient discount on the advantages of convenience and cost as may result from proximity of the services. These findings directly contradict with Meehan, Naidoo, Claassens, Lombard and Beyers (2014:6). The frame of their conclusions conforms to “a study in Uganda [which] showed the strongest predictors of satisfaction with services included accessibility, convenience and availability of services”. However, in Meehan et al., (2014) the focus was on validating mobile testing services as an alternative way to improve physical accessibility of services without a comparative framework as in this research and Njau et al., (2014). Importantly the study in Meehan et al., (2014) does not prescribed a workplace setting where the treatment of HIV/AIDS retains private interest between the employer and the employee. For employees in the workplace accessibility ceases to be only physical presence but incorporates considering the position utilisation of HIV/AIDS services will leave the certainty of continued employment, the social relationship with other employees and the privacy of one’s HIV status. Accordingly employees are able to perceive a positive service experience to the extent a testing site is able to secure minimal threat to confidentiality, privacy and continued employment.

5.1.3 To establish individual preferences on where to access HIV/AIDS services

The importance of accessibility to HTC services as a factor to encourage testing has been widely accepted in literature (Irigu et al., 2008, Corbet et al., (2006). There is a greater likelihood that individuals would test when testing services are found within their easy reach. However, findings in this research suggest the importance of convenience and physical accessibility as prime factors influencing potential testing behaviours is diminished by other social and environmental factors. In respect they affirm the research by Arimoto (2013) whose particular findings underlined the impact of fear to be discriminated against and desire to maintain social utility in the workplace as deterrents to individual testing in the workplace. The findings persuade a different approach to defining what convenience and accessibility must mean in HIV/AIDS intervention programs in the workplace to include the minimisation of environmental and social barriers which discourage testing behaviour in the workplace. A gross inconsistency between the desire to have HTC services in the workplace (94%) and those with propensity to actually test in the workplace mobile HTC facility (33 %) prevails in this research and it draws an informed inference to the practical impact of social and environmental factors like stigma, discrimination and employer motives to testing resulting in low HTC uptake levels. Consequently employees will develop negative attitudes towards onsite HTC services because they fail to adequately protect psychologically their desire for assured confidentiality. The life time loss of social value employee hold towards each other and the potential threat to job security should the employer discover one's positive HIV status cannot be sacrificed in these instances where alternative HTC services exist outside the workplace.

An interesting observation emerging from the research is the consistent variance between the health seeking behaviours between men and women as contained across general health related (Addis & Mahalik: 2003; Galdas, Cheater, & Marshall: 2005). Even if some of these studies are not workplace based, they are able to affirm the seemingly patent differences of how men emerge as more resistant to utilising health services compared to women. In this study 60% of the women participants indicated possibility of using HTC mobile services provided in the workplace

compared to 20% of the men. These findings are consistent with Arimoto (2013) who observed men have a greater propensity to use private hospital facilities compared to women. Responses from women indicate the impact of a greater responsibility on their part to secure family health through accessing condoms, participation in PMCT, education and lack of time to visit outside health services as some of the reasons which persuade them to use on-site HTC services. Women are left with fewer options to weigh the desirability of internal HTC services when they are pregnant and working with no free time to explore other service options. Their attitudes and perception to HTC services consequently becomes a by-product of time limitation and convenience rather than voluntary choice. An attempt to understand men's precepts to low testing even when services are readily available in the workplace can extend to the analysis of social theories about their desire to maintain a macho image and the influence of traditional beliefs on health seeking behaviour.

5.1.4 To investigate on the frequency of use of outsourced HIV/AIDS programs

Results obtained from this research suggest employees are making use external HTC services more frequently than those provided onsite. There is also a large disparity between the desire to have on-site HTC services and rate of potential use. Whereas 94% of the respondents expressed a positive desire to have HTC services in the workplace, only 34% indicated they would make use of on-site mobile testing services compared to 50% of the employees who would use external clinics and hospital facilities. The reasons why employees find internally provided HTC services practically inaccessible are a cause of concern. Results from randomised VCT testing trial in Zimbabwe (Corbett et al.) and other studies suggest the use of mobile VCT services in workplaces increases the potential for employees to test for HIV/AIDS. At least in poor resource settings like rural areas or refugee centres where access to other health facilities is practically limited mobile testing centres retain the capacity to initiate desire to test. A different perspective may apply in formal workplaces, especially in urban areas, because employees are somehow persuaded by the possibility of minimising work confined HIV-related prejudice by going to external health facilities.

It is also important to understand employee testing behaviour in the context of how the provision and availability of HIV/AIDS services have evolved in the local and

other African countries. There is evidence businesses have been slow to encapsulate the problem of the epidemic into a daily business and human resource challenge has left employee conditioned towards relying on public health services provided by the government. Employees have for the larger part also traditionally sought treatment from private clinics and public hospitals and would feel comfortable in familiar health care settings in non-health care settings in the workplace. The diversity of people one can meet at a public hospital, each with little interest in someone's affair removes a sense of fear of stigmatisation and panic to an individual. In contrast the close-knit family climate prevailing in the workplace provides a direct threat to one's desire for privacy and social acceptance and hence employees may opt out of employer assisted HTC services in the workplace.

5.1.5 To provide guidelines for organisations to face reality

Findings relating to low utilisation levels of HTC services by employees in the workplace are not new. Even where companies have gone further to enrol employees into company sponsored ART programs, resistance to participate in such programs has been observed (Govender et al., 2011). The results of this study are also consistent with patterns of low employee utilisation of internally provided epidemic interventions. It is patently evident employees are sceptical about employer motives for providing HTC in the workplace with eighteen out of thirty employees in this study believing the employer has access to employee HIV records when they use on-site facilities. The intermittent length of employee health cover or enrolment into ART programs run by the employer fails to meet the lifetime HIV treatment support employees may be looking for and which public health systems are able to provide. HIV/AIDS is a business cost organisations have to rationalise for sustainability and demonstration of corporate social investment, particularly in resource poor communities. The epidemic has been associated with increased business costs related to absenteeism, loss of productive time, funeral costs and dampened employee morale (Bollinger et al., 1999). Accordingly it is imperative for business to invest in programs which seek to reduce the impact of the epidemic on operational viability. Results of study indicating low level of utilisation can be used to provide clear guidelines to organisation on the addressing the real challenges of epidemic control in workplaces.

The following guidelines can be obtained:

- Organisations need to invest in improving their internal workplace environment to address negative perceptions lack of privacy, lack of anonymity when utilising services
- Employee welfare services need to be integrated with utilisation of public health systems which provide opportunities for lifetime access contrast to employer benefits tied to the duration of one's working life.
- Employees have a negative perception towards health care provisions in non-health care settings because of a perception they lack privacy, fear of stigma and discrimination.

5.2 Conclusion

As the problem of HIV/AIDS slowly entrenches into mainstream business management concern, the provision of workplace based welfare support services has slowly come to be seen as a priority to address competitive and cost implications in organisation. Conversely observations from earlier researches have long established the inherent expectation growing among employees in resource limited countries to be able to access HTC services in the workplace (Rosen et. al., 2003; Mahajan et al., 2007; Telemu, 2014). The findings of this research also note a high level of employees desire to have epidemic intervention programs in the workplace although this is accompanied with a low utilisation potential. Instead employees are inclined to use outsourced resources such as public hospitals and clinics. In a more elaborate cross-sectional study to explore the problem of burnt-out and use of HIV services among health care workers in Lusaka, Zambia, Kruse, Chapula et.al., (2009:4) observed "there was widespread belief that staff members do not seek testing at their clinic of employment, but instead go elsewhere to seek services (e.g. private clinics and nongovernmental organizations). Two points of conclusion can be arrived at from this observation. One, employees possess an innate practical dissonance with workplace based intervention programs which elicit some compensatory positive perception towards public health facility based interventions. Two, employers are not delivering their workplace based interventions to be perceived as genuine concern for employees' welfare. Their welfare schemes often qualify employee access to such services on such criteria as permanent employee

status, medical aid cover or places limitation on employee dependents. In situations where the majority of the employees found in a workplace are non-permanent staff peer alliance may involuntarily influence even those few permanent and qualifying from utilising those workplace based services in favour of externally located service providers which the majority of the employees use. In an environment as found in South Africa where employer and employee relations are characteristically hostile and incidences of employee layoffs are on the rise due to general economic decline, the prejudice associated with HIV/AIDS as a reason why the employer would also terminate employment contract has driven employees away from workplace based HTC centres which are perceived to breach privacy for the employer to know an individuals' HIV status. As Kruse, Chapula et al., (2009:6) further note "focus group participants also reported that if a health care provider were known to be living with HIV, he or she would lose the confidence of patients and his or her future employment prospects would be compromised". The investigation also recognised the influence of peer-induced stigma and perceived lack of confidentiality as other reasons restraining the health workers from taking HIV test in their own workplace. Accordingly health workers were found to utilise HIV testing facilities outside their own workplaces as opposed to internal resources.

It is also important to appreciate the early role the provision of ART in the workplace played in persuading employees to participate in workplace HIV/AIDS programs as costs and scarcity made treatment unavailable to many PLWHA. However, with access to ART and long term health support becoming much improved as a result of expanded governments and NGO (non-governmental organisations) public health initiatives, employees are no longer solely attracted to utilising on-site services to ensure access to treatment. Neither are costs and convenience of the workplace proving to be dominants factors to impact on perceptions on where an individual employee would test.

In most workplaces it is a trite observation to say employer and employee relations have been strained over the years as HIV/AIDS presented a huge on-going cost to business operations and incidentally increased the employees demand for welfare support from the employer. In the same frame it can be concluded the low utilisation

levels of HTC services in the workplace will get worse as long as general improvements in public health service delivery continues to improve because employees cannot practically disassociate on-site clinics and mobile testing centres with covert means through which the employer wants to breach their privacy and security of long term employment. Equally discouraging to employees is the way to cover benefit schemes in workplaces have been structured where they fail to provide a lifetime cover for the disease but limit benefits to the end of an individual's working life. Other schemes require subscription to medical aid cover in order for an individual to benefit and in others full cover may be provided for the employee but not family members such as partners and children. These issues all play a role in undermining the utilisation potential of on-site HTC services and in framing attitudinal dispositions.

5.3 Recommendations

Despite evidently low utilisation levels and lukewarm attitudes towards employer-centred HTC service provision, HIV/AIDS still remain a priority concern for organisations. In South Africa prevalence of HIV transmission remain high and this long terms cost and human resource is challenge to businesses. Apart from developing employee welfare programs which are non-discriminatory to non-permanent employees and family members, companies need to invest in internal educational programs to reduce the prevalence of stigma and discrimination. The industrial hiring practices in South Africa are leaning towards casualization of employment. This means should the current HIV/AIDS policy practices currently being followed remain stagnant only a smaller proportion of the company workforce will be covered and the provision of HTC service will become wasted investment as services will remain inaccessible to the majority.

Kruse, Chapula et al., (2009) recommended the development and promotion of parallel HTC services access system to appeal to different employee tastes. The positive perception towards public health (off-site) facilities observed in this study does not mean employees will not utilise on-site services. Individual tastes and preferences change over time and employers need to encourage employees to seek services where they feel most comfortable, even if it means leaving those found in the workplace.

5.4 Revisiting limitations

More than one company could be included in the research to provide for a broader representation of opinions. Employees at all levels in the organisations should be included to cover more levels and different views to contribute solving the stated problem.

LIST OF REFERENCES

Africa Science News Network, Kenya, 2008.

AIDS Education and Prevention, (2011). The Guilford Press 23 (6), 577–594

Anderson, T. N. & Louw-Potgieter, J. (2012). An implementation evaluation of a voluntary counselling and testing programme for the human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS), *SA Journal of Industrial Psychology*, 38(1), 1-10.

Arimoto, Y., Ito, S., Kudo, Y., Tsukada, K. (2013). Stigma, social relationship and HIV testing in the workplace: evidence from South Africa.

Bakuwa, R., & Mamman, A. (2012) Factors hindering the adoption of HIV/AIDS workplace policies: Evidence from private sector companies in Malawi. *The International Journal of Human Resource Management*, 23(14), 2917-2937.

Connelly, P., & Rosen, S. (2005). Will small and medium enterprises provide HIV/AIDS services to employees? An analysis of market demand *South African Journal of Economics* 73(s1) 613-626.

Corbett E.L, Dauya E, Matambo R et.al (2006) HIV incidence during a cluster-randomized trial of two strategies providing voluntary counselling and testing at the workplace, *Zimbabwe AIDS 2007*, Vol 21 No 4

Corbin, J. M., & Strauss, A. (1990). Grounded theory research: Procedures, canons, and evaluative criteria. *Qualitative sociology*, 13(1), 3-21.

Dieleman M, Biemba G, Mphuka, Sichinga-Sichali K , Sissolak D, van der Kwaak A & van der Wilt GJ () We are alsperceptions of the impact of HIV/AIDS on health workers in two districts in Zambia *Oxford Journals Medicine & Health Policy and Planning* Volume 22 Issue 3

Fox, A. M. (2010). The social determinants of HIV serostatus in sub-Saharan Africa: an inverse relationship between poverty and HIV? *Public Health Reports*, 125

Fylkesnes K & Siziya S. A. (2004) Randomized trial on acceptability of voluntary HIV counselling and testing, *Tropical Medicine and International Health*, volume 9 no 5

Galdas, P. M., Cheater, F. & Marshall, P. (2005), Men and health help-seeking behaviour: literature review. *Journal of Advanced Nursing*, 49

Gavin G & Quinlan T (2008) 'Health Management' in the Private Sector in the Context of HIV/AIDS: Progress and Challenges Faced by Company Programmes in South Africa, *Sustainable Development* 17(1)

Gillespie, S. (2008). Poverty, Food Insecurity, HIV Vulnerability and the Impacts of AIDS in sub-Saharan Africa, *IDS Bulletin*, 39: 10–18.

Govender K, Akintola O, George G, Petersen I, Bhagwanjee A & Reardon C (2011) Psychosocial and behavioural correlates of attitudes towards antiretroviral therapy (ART) in a sample of South African mineworkers, *Journal of Social Aspects of HIV/AIDS VOL. 8 NO. 2*.

Haacker M. (2002). The Economic Consequences of HIV/AIDS in Southern Africa *IMF Working Paper* 02/38

Hontelez, J. A. Newell, M. L. Bland, R. M., Munnely, K., Lessells, R. J., & Bärnighausen, T. (2012) Human resources needs for universal access to antiretroviral therapy in South Africa: a time and motion study, *Human Resource Health*, 10(1), 39.

Irungu, T. K., Varkey, P., Cha, S. & Patterson J. M. (2008). HIV voluntary counselling and testing in Nakuru, Kenya: findings from a community survey *HIV medicine*, 9(2)
Johnson D & Cheng X (2014) The role of private health providers in HIV testing: analysis of data from 18 countries, *International Journal for Equity in Health*

Joseph, H.A, Fasula M.A, Morgan R.L, Stuckey A, M.E Alvarez, Margolis A, Stratford D, & Dooley Jr S.W (2011) "The anticipation alone could kill you": Past and Potential Clients' Perspectives on HIV Testing in Non-Health Care Settings

Jürgensen M, Tuba M Fylkesnes K and Blystad A (2012).The burden of knowing: balancing benefits and barriers in HIV testing decisions. A qualitative study from Zambia, *BMC Health Services Research*

Kassile T, Anicetus H, Kukula R, & Mmbando B.P (2014) Health and social support services to HIV/AIDS infected individuals in Tanzania: employees and employers perceptions. *BMC Public Health* 2014

Kothari (2004) Research Methodology: Methods and Techniques 2nd Revised Edition, New Age International Publishers

Kruse, G.R., Chapula, B.T., Ikeda,T., Nkhoma M., Quiterio N., Pankratz, D., Mataka, K., Chi, B.H., Bond, V. and Stewart, E.R. (2009). Burnout and use of HIV services among health care workers in Lusaka District, Zambia: a cross-sectional study, *Human Resources for Health* 2009, 7:55 doi:10.1186/1478-4491-7-55

Mahajana A.P, Colvin M, Rudatsikiraa J & Ettl D (2007) An overview of HIV/AIDS workplace policies and programmes in southern Africa 2007 Lippincott

Masanjala, W. (2007). The poverty-HIV/AIDS nexus in Africa: a livelihood approach. *Social Science & Medicine*, 64(5), 1032-1041.

Mbonu C.N, den Borne B & De Vries (2009) Stigma of People with HIV/AIDS IN SubSaharan Africa: *A Literature Review Journal of Tropical Medicine Vol. 2009*

Meehan et al.: (2014) Characteristics of clients who access mobile compared to clinic HIV counselling and testing services: a matched study from Cape Town South Africa. *BMC Health Services Research* 2014 14:658.

Mundy J & Dickinson D (2004) Factors affecting the uptake of voluntary HIV/AIDS counselling and testing (VCT) services in the workplace; HIV/AIDS in the Workplace, Research Symposium University of the Wits 29 and 30 June 2004

Museve J, George E.G & Labongo C. L (2013) Analysis of Uptake in HIV Voluntary Counselling and Testing Services: Case of Mount Kenya University Students

Mwale M (2014) Factors Determining Voluntary Counselling and Testing (VCT) for the Human Immunodeficiency Virus (HIV) among Low Income Women: Focus Group Findings from Rural, Urban, and Peri-Urban Women Groups in Lilongwe District-Malawi *Journal of Basic & Applied Sciences*, 2014

Nattrass, N. (2011). AIDS Policy in Post-Apartheid South Africa. *After Apartheid: The Second Decade of Democracy*, 181-198.

Neluheni T.P (2005), The effect of conducting workplace Voluntary Counselling and Testing (VCT) on-site on VCT uptake, Stellenbosch University

Phakathi Z, Van Royen H, Fritz K & Ritcher L (2011) The influence of antiretroviral treatment on willingness to test: a qualitative study in rural KwaZulu Natal South Africa, *African Journal of AIDS Research* 2011 10(2)

Rosen, S. Feely, F. Connelly, P. and Simon, J (2007). The Private Sector and HIV/AIDS in Africa: taking stock of 6 years of applied research, Lippincott Williams
Schneider, H. & Fassin, D. (2002). Denial and defiance: a socio-political analysis of AIDS in South Africa. *Aids*, 16, S45-S51

Scott K, Campbell, Skovdal M, Madanhire C, Nyamukapa C & Gregson S (2013). What can companies do to support HIV-positive workers? Recommendations for medium and large sized African workplaces, *International Journal of Workplace Health Management* 6(3) pp 174-188

Stop Aids Now (2009) Addressing HIV and AIDS in the workplace Lessons Learnt from Civil Society Organisations and Donors

Tadele G (2013). Introduction in: Tadele, G., & Kloos, H. (Eds.) (2013) Vulnerabilities Impacts and Responses to HIV/AIDS in Sub-Saharan Africa. Palgrave Macmillan.

Tamiru M, Haidar J (2010) Hospital Bed Occupancy and HIV/AIDS in three Major Public Hospitals of Addis Ababa, Ethiopia International journal of biomedical science: ..., 2010 - ncbi.nlm.nih.gov

Taylor, K., DeYoung, P., & Boldrini, F. (2004). Business and HIV/AIDS: a global snapshot. *Europe*, 28(4)3.

Terre Blanche M & Kelly K (2004) Interpretive Methods In Terre Blanche and Durrheim (Ed.) Research in Practice: applied methods for social sciences UCT Press

UNAIDS Annual Report 2008

UNAIDS Fact Sheet 2014

UNAIDS Global Report 2013

UNAIDS World AIDS Day Report 2011

UNAIDS World AIDS Day Report 2012

UNICEF 2014

Van Niekerk, A. (2005). Rolling out Antiretroviral treatment in South Africa: economic and ethical challenges: In A. Van Niekerk & L.M. Kopelman (Eds), Ethics & AIDS in Africa- The Challenge to our Thinking. Claremont. New Africa Books

Versteeg, M., (2004). A licence to choose?. HIV/AIDS workplace responses from South African profit-making companies in context; HIV/AIDS in the Workplace Research Symposium University of the Witwatersrand 29 and 30 June 2004

Wyk B., Research Design and Methods Part 1, University of the Western Cape



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CONSENT TO PARTICIPATE IN RESEARCH

Employee perceptions towards outsourcing of HIV/AIDS services

You are kindly asked to participate in a research study conducted by Tendai Makwara from the Africa Centre for HIV/AIDS Management, Department of Economic and Management Sciences at Stellenbosch University. The study investigates employee perceptions towards outsourcing of HIV/AIDS in the workplace and the results will contribute to inform institution the value of this strategy to be more economical and discrete. It will also serve as a source to prepare the writing of a thesis in partial fulfilment of the requirements of MPhil (HIV/AIDS) Management studies. You were selected to participate in this study because you are a permanent employee who is potentially covered by your workplace employee welfare program which provides HIV/AIDS services among other benefits and you are in a position to contribute relevant information to the topic under investigation.

1. PURPOSE OF THE STUDY

The study is designed to assess employee attitudes and perceptions towards the outsourcing of HIV/AIDS services in the workplace and their impact on uptake levels. The purpose is to gain insight into the suitability and effectiveness of providing external HIV/AIDS services as part of employee welfare services and to better understand employee HIV/AIDS-related health seeking in the workplace.

2. PROCEDURES

If you volunteer to participate in this study, we would ask you to do the following things:

1. Be willing to take part in a single questionnaire personal interview conducted by myself
2. Give responses to questions truthfully and to the best of your knowledge. You may choose not to answer specific questions you are not comfortable with.
3. Allow your responses to form part of the results of this research which would be stored at Stellenbosch University.
4. Be available at set times to conduct the interview.

The interview will take 30 -45 minutes of your time.

3. POTENTIAL RISKS AND DISCOMFORTS

No personal demographic and employment related data will be collected directly with direct link to study participants. For purpose of analysis only gender and age (collected within given range) will be collected. The sponsoring organization has waived its identity to be visibly associated with this study and this adds to anonymity and confidentiality employees may require in work-related situations. HIV/AIDS related discussions may involve issues that conflict with individual cultural and religious moral. Study participants will be advised of their right to refuse to answer or discuss questions that they are not comfortable with.

4. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

Although no direct material benefit will come to you as a study participant your contribution to building knowledge about employee attitudes to outsourced HIV/AIDS services in the workplace is appreciated. The research benefits two main societies- the workplace and the academic study on the epidemic. In the workplace employee attitudes to external HIV/AIDS services will influence how employee welfare programs are to be implemented and what services to offer for in-house epidemic control practices. This study also contributes the growing body of academic knowledge about HIV/AIDS.

5. PAYMENT FOR PARTICIPATION

Study participants will not receive payment. This is an academic research to fulfil study requirements and is not sponsored for commercial gain.

6. CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means of an unrecorded identity of the study participants nor their organization, non-distribution of the result to any other external body except Stellenbosch University where the record is to be kept. Study participants maintain a right to peruse the final report submitted to University if they deem it so necessary to see if confidentiality clauses have been observed. The company has given its permission for this study to be conducted in this workplace subject to strict confidentiality that neither its name nor its employees name be revealed.

7. PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so.

IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research, please feel free to contact

Tendai Makwara (Principal Investigator) on Email: makwara.t@gmail.com and Cell number: +27789239849

Professor Elza Thomson (Supervisor) on: elzathomson@gmail.com

8. RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research subject, contact Ms Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] at the Division for Research Development.

SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE

The information above was described to me _____ the research participant by Tendai Makwara in English and I am in command of this language. I was given the opportunity to ask questions and these questions were answered to my satisfaction.

I hereby consent to voluntarily participate in this study. I have been given a copy of this form.

Name of Subject/Participant

Name of Legal Representative (if applicable)

Signature of Subject/Participant or Legal Representative

Date

SIGNATURE OF INVESTIGATOR

I declare that I explained the information given in this document to _____ and/or [his/her] representative _____ [*name of the representative*]. He/she was encouraged and given ample time to ask me any questions. This conversation was conducted in English.

Signature of Investigator

Date

Research Questionnaire

Measuring Perception towards Outsourcing of HIV/AIDS services

1. In which age group do you fall
 18-24
 25-34
 35-44
 45 and above

2. Can your name some of the employee health services you wish the company provide here at your workplace

3. Talking about HIV/AIDS, do you think it is necessary for the company to have an HIV/AIDS health clinic onsite for testing, counselling, condom distribution and ART
 Yes/ No
 If No why _____

4. Where would you prefer to go for HIV/AIDS test or counselling services?
 a) Outside the workplace
 b) At mobile caravans that come to the workplace
 c) Has never tested
 d) Don't wish to say

5. When deciding on where to go for HIV/AIDS test/ Counselling / how important are the following elements in shaping your choice? (Mark one for each)

	None	Not Really	Important	Very Much	Rating (q6)
a) Confidentiality	1	2	3	4	
b) Access to ART	1	2		3	4
c) Ease of accessibility	1	2		3	4
d) Staff professional outlook	1	2	3	4	
e) Able to go with partner	1	2	3	4	
f) Cost of services		1	2	3	4
g) Anonymity		1	2	3	4

6. On a scale of 1–5 (1 = very bad, 5 = perfect) how do you rate external HIV/AIDS service providers (public clinics, private doctors) on the elements in Question 5?

7. Which word best describes your likely reaction if you overheard your manager/ fellow employees discussing about your HIV status
 - a) Disappointed / angry
 - b) Don't care / do nothing about it
 - c) Confront them / report to senior management

8. Mark AGREE/DISAGREE to each of the following statements:
 - a) Most employees would prefer to test away from the workplace
AGREE/DISAGREE
 - b) The employer will gain access to my HIV information if I test in the workplace
AGREE/DISAGREE
 - c) I feel secure to consult about HIV/AIDS at public centres than I would at work
AGREE/DISAGREE
 - d) It is more private and confidential to test at work than at a VCT centre at clinic
AGREE/DISAGREE
 - e) If the company could provide ARVs here I believe many employees would be willing to test on-site
AGREE/DISAGREE
 - f) If other employees could see me taking condoms from the dispensers I would immediately stop.
AGREE/DISAGREE

9. In South Africa ARVs are given for free at public hospitals. Generally why do you believe people resist testing for HIV/AIDS even if they are assured of access to treatment? _____

10. List any barriers to accessing HIV/AIDS health care services that employees do face in your workplace as a result of relying on external health centres.

11. Can you rate the quality of service you experienced the last time you visited an external health services provider

Bad _____ Satisfactory _____ Very Good _____ Excellent _____